STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNHURST HEALTHCARE	5225 W MORRIS ST INDIANAPOLIS, IN46241

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: February 21, 22, 23, & 24, 2011 Facility Number: 000385 Provider Number: 15E667 AIM Number: 100291340 Survey Team: Rhonda Stout RN TC Marcy Smith RN Leia Alley RN (February 24, 2011) Census bed type: NF: 36 Total: 36 Census payor type: Medicaid: 36 Total: 36 Sample: 11 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 3/03/11 by Suzanne Williams, RN	F0000	Preparation and execution of this plan of correction does not constitute an admission to or an agreement by the provider with the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The plan of correction is prepared and executed soley because it is required by the provisions of federal and state law. Lynhurst Healthcare maintains that the alleged deficiencies do not individually or collectively jeopordize the health and/or safety of its residnets nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthemore, Lynhurst Healthcare asserts that it is and was in substantial compliance with the regulations governing the operation of long term care facilities; that this Plan of Correction in its entirety, constitutes this provider's allegation of compliance.Completion dates are provided for procedural processing purposes to comply with federal and state regulations and to correlate with the most recent contemplated or accomplished corrective action. These do not necessarily chronologically correspond to the date that Lynhurst Healthcare is under the opinion that it was in participation or that corrective	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			action was necessary.	

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F0253 SS=C	Based on observation, the facility failed to ensure the resident environment was functional, by failing to ensure all window blinds functioned properly and drawers for storing personal belongings functioned properly, and reading lights worked. The lack of proper functioning window blinds affected residents who reside in rooms 7, 12, 14, and 18. The lack of proper functioning window blinds affected 10 out of 36 residents who reside in the facility. One set of vertical blinds in the dining/activity room did not function properly potentially affecting all 36 residents who used the room. Drawers used in the storage of personal property affected residents who reside in room 7, and 12 bed 2. The non-functioning drawers affected 2 out of 36 residents who reside in the facility. Findings included: During the 2/24/2011, 10:00 a.m., environmental tour accompanied by the building maintenance man, the following concerns were observed: a) Window blinds did not function properly in rooms 7, 12, 14, and 18. The blinds in room 7, 12, and 18 were missing the adjustment rods. In the main dining room/activity room, the adjustment cord on one of the vertical	F0253	F02531)All residents have the potential to be affected by this deficiency.The Administrator has had the Maintenance Director replace window blinds , repair or place orders for dresser drawers/dressers and repair/replace reading lights. (Window blinds and reading lights, completed 2/28/2011. Orders for furniture to replace bedside tables in rooms 12,14 and 18, have been completed. The dresser drawer in room 7 has been repaired.)2) How the facility will ID other resident having the potential to be affected by the same deficient practice and what corrective action will be taken:An evaluation of each resident's room and of all common areas has been completed. New dressers have been ordered and any malfunctioning personal furniture has been identified and repaired or has been ordered (ie: a furniture order) to be replaced.(Window blinds and reading lights, completed 2/28/2011) Order was placed 3-9-11 for three (3) Heartland bedside 3 drawer cabinet.3) The systemic changes the facility has made, to prevent reoccurrence of this tag:The Administrator and the Maintenance Director made inspection/environmental rounds of the resident rooms and common areas on 2/28/2011.The Maintenance Director will make his inspection rounds in each	03/26/2011

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	blinds was stuck and would not open or closed the blinds. b) Two drawers used to store personal belongings, in room 7, were tilting upward and appeared to be not on track. One drawer in room 12 was sitting on the floor. c) Reading lights would not turn on in room 3 bed 2 and room 16 bed 1. There was no reading light for room 3 bed 1. 3.1-19(f)		resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing, the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection rounds will be documented in written form.4) Responsibility for and monitoring for, the corrective actions for F0253:The Maintenance Director will be responsible to document all inspection rounds, to include all resident furniture and lighting, in writing and forward these to the Director of Nursing and the Administrator of the facility.The Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing , the	

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			Administrator and the Housekeeping Supervisor. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing ,the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection/environmental rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection/environmental rounds will be documented in written form.	

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F0282 SS=E	A. Based on record review and interview, the facility failed to ensure physician orders for laboratory services were followed in a timely manner for 3 of 10 residents reviewed for timely laboratory services in a sample of 10 and failed to ensure the plan of care was followed for a resident receiving dialysis for 1 of 1 resident receiving dialysis in a sample of 10. (Residents # 32, 5, 9, 36) B. Based on record review and interview, the facility failed to ensure a resident had his blood pressure taken prior to their administration of medication, as ordered by the physician. This affected 1 of 10 residents reviewed for following physician's orders related to medication administration out of a sample of 10. (Resident #36) Findings included: A. A current facility admissions packet provided by the Social Service Director on 2/21/2011, under the category of Medical Care and Treatment indicated the resident have the right to, "Services necessary to attain or maintain your highest practicable level of functioning." A current facility policy for "Resident Neglect, Abuse, and Misappropriation of	F0282	F02821) What actions will be accomplished for those residents found to have been affected by the deficeint practice:A) (requirement)All residents have the potential to be affected by this deficeincy.However, under further physician review, no resident was noted to be affected negatively in this particular instance.The facility realizes it's part in the safe keeping, safe medication administration and the practice of safely monitoring medications.The facility takes this realization seriously.3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents. There, according to contractural agreements, could be a 60 day waiting period to make the change form one laboratory to the other.On 3-16-2011 the ARNP was made aware of lab difficulties and audited residents for any lab adjustments. The Director of Nursing (or her designee) will audit labs and lab orders each month for the remainder of 2011.Dialysis for resident #36: Circle Center Dialysis/Lisa, was contacted 3-16-11, by this author. This dialysis center, as all dialysis centers do, perform certain vital sign measurements and weights, along with other	03/26/2011

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	Property", dated 04/2000 and revised on 02/2003, indicated "Staff...will be monitored...by their perspective supervisors to ensure that the residents receive appropriate care and services..." 1. The clinical record review for Resident #32 was reviewed on 2/22/2011 at 1:50 p.m. The diagnoses for Resident #32 included, but were not limited to, schizophrenia, bipolar affective disorder, anxiety, transient cerebral ischemia, and osteoporosis. A physician's order dated 7/26/2010, indicated Resident #32 was to have a complete blood count (CBC), a complete metabolic panel (CMP), and liver function test every three months. A physician's order dated 8/12/2010, indicated Resident #32 was to have a single vitamin D level drawn. A physician's order dated 10/28/2010, indicated Resident #32 was to have a single vitamin D level drawn. Review of the lab reports for Resident #32 indicated CBCs, CMPs, and liver function tests were completed on 7/27/2010 and 1/12/2011. There were no lab results located in the chart for the October CBC,CMP, and liver function tests that		testing that is normally sent to each facility. This was not found to be the case with Lynhurst Healthcare and the dialysis center was advised and agreed to send paperwork via fax monthly. (summaries of care). The center also was advised and agrees with the following:The facility has composed a "Dialysis Form" which will accompany the resident to the dialysis center,each scheduled visit; where the nurses at dialysis will complete the form and send it back to this facility when the resident returns from dialysis. This form lists blood pressures before and after the dialysis treatment, along with weights and any labs or contraindications that may have occurred with the dialysis treatment.These forms will become a part of the residents medical records.Resident #9: This resident was previously care planned for non-compliance with care, including laboratory testings. Therefore, should the resident refuse, the facility will try again and again but it is felt to be within this resident's rights to refuse. Risks and benefits are explained and the attending doctor is kept aware. The facility has also had Psych services attempt to evaluate this resident, several times, to which she also refuses and also has that right to do so.B) (requirement)The facility started a new form on 3-4-11 to	

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	were ordered every three months on 7/26/2010. There were no lab results for the 8/12/2010 vitamin D level and there were two results for the vitamin D level ordered on 10/28/2010. One of the vitamin D results was dated 11/3/2010 and the other was dated 11/8/2010. There was a PT/INR dated 1/26/2011, and a urinalysis with culture and sensitivity dated 7/6/2010, in which there was no written physician's order provided for these test. In an interview with the Director of Nursing (DON) and the Administrator on 2/24/2011 at 3:15 p.m., in regard to the timeliness of laboratory tests being done and tests being performed not having a physician's order, they indicated they were unaware that a problem existed with the laboratory service and that they were in the process of acquiring another laboratory to provide their service. The DON indicated the nurses are responsible for ordering the labs. 2. The clinical record for Resident #5 was reviewed on 2/23/11 at 2:25 p.m. The diagnoses for Resident #5 included, but were not limited to, insulin dependent diabetes mellitus, hypertension, chronic kidney disease, congestive heart failure,		ensure proper documentation of all necessary vital sign measurements for all residents.Staff who are found to be non compliant with any doctors orders, including the documentaion of required vital signs, will be given written counsel and placed into the facility's corrective step program.3-16-11 This author contacted the facilitys pharmacy and is requesting follow up medication administration in-services for those nurses and Qualified Medication Aides that sign off on medication sheets. The facility is also requesting a supervised medication pass with a pharmacy representative, for all facility Qualified Medication Aides.In-services for nurses and QMA's will be done four times per year regarding the medication pass and the documentations required thereof.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken:All residents have the potential to be affected by this deficeincy.However, under further physician review, no resident was noted to be affected negatively in this particular instance. It was noted by our surveyors that the facility's present contracted laboratory services, were not complying with doctor ordered time schedules in some	

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	and vascular dementia with delirium. A physician's order dated 5/14/2010, indicated Resident #5 was to have a hemoglobin A1C every 3 months. Review of the lab reports for Resident #5 indicated hemoglobin A1C tests were completed for May and August. The November 2011 hemoglobin A1C was done on 10/29/2010 and the February 2011 hemoglobin A1C was done on 1/20/2011. There was a urinalysis done on 6/23/2010 in which there was no physician's order. In an interview with the Director of Nursing (DON) and the Administrator on 2/24/2011 at 3:15 p.m., in regard to the timeliness of laboratory tests being done and tests being performed not having a physician's order, they indicated that they were unaware that a problem existed with the laboratory service, and they were in the process of acquiring another laboratory to provide their service. The DON indicated the nurses are responsible for ordering the labs. 3. The clinical record for Resident #9 was reviewed on 2/23/2011 at 10:07 a.m. The diagnoses for Resident #9 included,		instances. Residents 32-36-5 (three- out of a possible 40 residents.)The facility realizes it's part in the safe keeping, safe medication administration ,the practice of safely monitoring medications and laboratory orders.The facility takes this realization seriously.3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents.On 3-16-2011 the ARNP was made aware of lab difficulties and audited residents for any ordered lab adjustments. Lab work has been completed.The Director of Nursing (or her designee) will audit labs and lab orders each month for the remainder of 2011.As of April 1st 2011, the actual "MAR" (medication administration records, will be delivered pre-printed with what particular vital signs must be taken prior to and/or after particular medication admininstration. (Re-writes do not begin until the beginning of the month.)As of March 26th 2011, the acting Unit Manager will be responsible to check the Medication Administration Records on a daily basis for a 14 day period (documented); then a weekly basis for a 4 month period (documented); followed by a	

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	but were not limited to, insulin dependent diabetes mellitus, cardiomegaly, chronic obstructive pulmonary disease, seizures, and osteoporosis. A physician's order dated 7/7/2010, indicated Resident #9 was to have a hemoglobin A1C, complete metabolic profile, and a Dilantin level every 3 months. Review of the lab reports for Resident #9 indicated no lab results for January 2011. There were results for July and November. There were reports from the laboratory indicating the tests were canceled on January 3, 4, 12, 14, and 18. There were physician progress notes dated 1/12/2011, indicating on 1/3/2011 and 1/5/2011 that the tests were canceled due to patient declined or the release was not signed. In an interview with the Director of Nursing (DON) and the Administrator on 2/24/2011 at 3:15 p.m., in regard to the timeliness of laboratory tests being done and tests being performed not having a physician's order, they indicated they were unaware that a problem existed with the laboratory service, and they were in the process of acquiring another laboratory provide their service. The DON indicated		monthly basis (documented) for the remainder of the year2011. Also the acting Unit Manager will be providing follow up with those nurses or QMA's accountable, should there be "holes" (undocumented segments), for those "holes" and to ensure that the vital signs are being recorded properly.Resident #9: This resident was previously care planned for non-compliance with care, including laboratory testings. Therefore, should the resident refuse, the facility will try again and again but it is felt to be within this resident's rights to refuse. Risks and benefits are explained and the attending doctor is kept aware. The facility has also had Psych services attempt to evaluate this resident, several times, to which she also refuses and also has that right to do so.3) What systemic changes will be made to ensure the deficient practice does not recur:Laboratory Issues:All residents have the potential to be affected by this deficeincy.However, under further physician review, no resident was noted to be affected negatively in this particular instance.3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents.Lab	

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	the nurses are responsible for ordering the labs. 4. The clinical record for Resident #36 was reviewed on 2/22/2011 at 11:15 a.m. The diagnoses for Resident #36 included, but were not limited to, end stage renal disease, insulin dependent diabetes mellitus, diabetic gastroparesis, and hypertension. The clinical record had no reports given to the facility from the dialysis center with the details from the dialysis session. A nursing note dated 12/2/2011 indicated the facility, "received a good report from the dialysis providers," but did not document any vital signs or lab results that were taken during the dialysis session. One nursing noted dated 2/8/2011, indicated the dietitian from the dialysis center called about the resident's diet. A recapitulated physician's order indicated to, "check shunt site every shift for positive thrill and bruit and document on the treatment sheet." During an interview with the Administrator on 2/23/2011 at 2:20 p.m., in regard to having a policy for the continuum of care for dialysis residents coming from dialysis back to the facility,		results and refusals are then followed by this new lab and made available to the facility via fax and on line.This lab also has a customer service representative who will be scehduled to come into the facility and audit ordered labs, completed labs, etc.Vital Signs Issue:As of March 26th 2011, the acting Unit Manager will be responsible to check the Medication Administration Records on a daily basis for a 14 day period (documented); then a weekly basis for a 4 month period (documented); followed by a monthly basis (documented) for the remainder of the year2011. Also the acting Unit Manager will be providing follow up with those nurses or QMA's accountable, should there be "holes" (undocumented segments), for those "holes" and to ensure that the vital signs are being recorded properly.As of April 1st 2011, the actual "MAR" (medication administration records, will be delivered pre-printed with what particular vital signs must be taken prior to and/or after particular medication admininstration. (Re-writes do not begin until the beginning of the month.)Dialysis for resident #36: (and future dialysis residents)Circle Center Dialysis/Lisa, was contacted 3-16-11, by this author. This dialysis center, as all dialysis centers do, perform certain vital	

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	she indicated the facility did not have a current policy. B.1. The record for Resident #36 was reviewed on 2/22/2011 at 11:15 a.m. Diagnoses for Resident #36 included, but were not limited to, end stage renal disease, insulin dependent diabetes mellitus, hypertension, and anemia. A physician's order that originated upon admission on 10/26/2010 indicated the resident was to have his blood pressure taken prior to the administration of Metoprolol which the resident took at 9 a.m. and 5 p.m., except for the days he went to dialysis on Tuesdays, Thursdays, and Saturdays in which he did not take this medication. The medication administration records for Resident #36 indicated he did not have his blood pressure taken for the following dates and times prior to the administration of his Metoprolol. November 2010: 9 a.m. : 8, 15, 21, 24, 26, and 29. 5 p.m. : 3, 4, 6, 7, 11, 14, 17, 18, 24, 25, 29, and 30 December 2010: 9 a.m. : 24 and 26 5 p.m. : 1, 2, 4, 9, 10, 12, 13, and 19.		sign measurements and weights, along with other testing that is normally sent to each facility. This was not found to be the case with Lynhurst Healthcare and the dialysis center was advised and agreed to send paperwork via fax monthly.(summaries of care). These will become part of the reisdents medical records. The center also was advised and agrees with the following:The facility has composed a "Dialysis Form" which will accompany the resident to the dialysis center,each scheduled visit; where the nurses at dialysis will complete the form and send it back to this facility when the resident returns from dialysis. This form lists blood pressures before and after the dialysis treatment, along with weights and any labs or contraindications that may have occurred with the dialysis treatment.These forms will become a part of the residents medical records.4) How the corrective actions will be monitored to ensure the deficient practice does not recur: Laboratory:3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents.Lab results and refusals are then	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	January 2011: 9 a.m. : 3, 9, 10, 16, 24, and 30. 5 p.m. : 1, 3, 5, 12, 15, 20, 24, and 30. February 2011: 9 a.m. : 4 and 14. During exit on 2/23/2011 at 5:45 p.m., more documentation was requested in regard to blood pressures being assessed prior to the administration of the medication, Metoprolol. Several 24 hour report sheets and CNAs vital sign sheets were produced except for the above dates which the facility could not provide anymore information. 3.1-35(g)(2)		followed by this new lab and made available to the facility via fax and on line.This lab also has a customer service representative who will be scehduled to come into the facility and audit ordered labs, completed labs, etc.3-16-2011 The facility interviewed a new laboratory agency; Med Lab and found them to have improved upon laboratory measures that are utilized in Geriatric Facilities. The facility has accepted their offer to service our residents.On 3-16-2011 the ARNP was made aware of lab difficulties and audited residents for any ordered lab adjustments. Lab work has been completed.The Director of Nursing (or her designee) will audit labs and lab orders each month for the remainder of 2011.Vital Signs Issue:As of March 26th 2011, the acting Unit Manager will be responsible to check the Medication Administration Records on a daily basis for a 14 day period (documented); then a weekly basis for a 4 month period (documented); followed by a monthly basis (documented) for the remainder of the year2011. Also the acting Unit Manager will be providing follow up with those nurses or QMA's accountable, should there be "holes" (undocumented segments), for those "holes" and to ensure that the vital signs are being recorded	

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	15E667	A. BUILDING _____ B. WING _____	02/24/2011

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			properly.The Unit Manger works under the direct supervision of the Director Of Nursing and will report to her.Dialysis:The facility has composed a "Dialysis Form" which will accompany the resident to the dialysis center,each scheduled visit; where the nurses at dialysis will complete the form and send it back to this facility when the resident returns from dialysis. This form lists blood pressures before and after the dialysis treatment, along with weights and any labs or contraindications that may have occurred with the dialysis treatment.These forms will become a part of the residents medical records.The Director of Nursing and/or her designess will monitor that these new forms are being sent out to and completed and returned to this facility. The monitoring of these forms will take place weekly for the next 8 (eight) weeks and drop to monthly monitoring for the remainder of the year 2011.Resident #9: The faclity will continue to offer this resident laboratory services as prescribed by her attending doctor. The facility will document refusals of laboratory services.The facility had previously discussed other placement for this resident and we were successful in locating other placement; however, this resident once confronted with the actuality of leaving, refused	

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			the alternate placement. Lynhurst is this resident's home and we hope to have the privelge to care for her for as long as she desires it to be.	

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F0431 SS=E	Based on observation, record review and interview, the facility failed to ensure medications were labeled with open dates on 10 of 19 vials of opened insulin in a basket kept in the refrigerator. This had the potential to affect 8 of 12 residents receiving insulin from that basket. (Residents #7, #24, #35, #14, #1, #5, #10, #9) Findings included: A undated policy titled "Insulin Administration," received from the Administrator on 2/24/11 at 4:30 p.m., indicated "...4. The nurse shall label the insulin bottle with a date and initials upon opening...5. The nurse shall dispose of opened insulin bottles after 28 days from the date labeled on the bottle (the date written on the bottle when it is opened, dated and initialed by the nurse)...." An undated job description for a staff nurse, received from the Administrator on 2/24/11 at 2:00 p.m. and deemed current, indicated "...Charting and Documentation...Ensure medication containers are signed and dated when opened..." During a review of the medication refrigerator on 2/24/11 at 12:30 p.m. with	F0431	F04311) What actions will be accomplished for those residents found to have been affected by this deficient practice:Although no residents were found to be affected by the listed medications not having 'open dates', the facility recognizes that prudent nursing practice mst be adhered to and that the potential for all residents to be affected by this deficiency must be avoided.The facility pharmacy performed an inspection, on 3/1/2011 and will return in two weeks to perform the same.Pharmacy will also utilize a monthly schedule of physically auditing the medication and treatment carts. All nursing staff (certified and licensed) will be in-serviced on the proper storage, opening containers and placing 'date of open' on the containers when opened.This in-service will be done by the facility and the pharmacy, on different dates and at different times, to ensure the message gets to the entire nursing staff.The nursing staff will be monitored weekly for three (3) months starting March 21st 2011 by the Director of Nursing (or her designee) to confirm that opened medication containers are properly stored and labeled; both in the medication and treatment carts and in the Medication Room proper. June 16th 2011 the monitoring schedule of the Director of Nursing (or her	03/26/2011

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	Licensed Practical Nurse (LPN) #1, 19 vials of opened insulin were observed in a basket. 10 of these vials, belonging to 8 residents, did not have the date opened marked on them. (Residents #7, #24, #35, #14, #1, #10, #5 and #9). During an interview with LPN #1 on 2/24/11 at 12:45 p.m. she indicated, "We're always supposed to label the vials with open dates." During an interview with the Administrator on 2/24/11 at 2:45 p.m., regarding the 10 vials of insulin without open dates, she indicated "They know they're supposed to put a date on everything they open." 3.1-25(j) 3.1-25(k)		designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011.2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:The facility pharmacy performed an inspection to include the medication and treatment carts and the Medication Room proper, on 3/1/2011 and will return in two weeks from that date to perform the same. All insulin vials have been dated when opened or replaced, at this time.Pharmacy will also utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. All nursing staff (certified and licensed) will be in-serviced on the proper storage, opening containers and placing 'date of open' on the containers when opened.This in-service will be done by the facility and the pharmacy, on different dates and at different times, to ensure the message gets to the entire nursing staff.The nursing staff will be monitored weekly for three (3) months starting March 21st 2011 by the Director of Nursing (or her designee) to confirm that all opened medication containers are properly stored and labeled;	

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			both in the medication and treatment carts and in the Medication Room proper.June 16th 2011 the monitoring schedule of the Director of Nursing (or her designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011.3) What systemic changes will be made to ensure the deficient practice does not recur:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with a full copy of their findings during the audit. All nursing staff (certified and licensed) will be in-serviced on the proper storage, opening containers and placing 'date of open' on the containers when opened.This in-service will be done by the facility and the pharmacy, on different dates and at different times, to ensure the message gets to the entire nursing staff.The nursing staff will be monitored weekly for three (3) months starting March 21st 2011 by the Director of Nursing (or her designee) to confirm that all opened medication containers are properly stored and labeled; both in the medication and treatment carts and in the	

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			Medication Room proper.Non compliant employees will then be identified and counseled in writing, by the Director of Nursing.June 16th 2011 the monitoring schedule of the Director of Nursing (or designee) will be decreased to bi-weekly for three (3) months and then go to a monthly basis for the remainder of the year 2011.The facility will be scheduling a medication pass audit with the pharmacy and our Qualified Medication Aides.Each insulin vial medication container will have colored dots placed on the tops of the containers; as a place indicating 'open dates' along with each vial being dated as when opened. This process will be audited starting March 21st 2011 by the same aforementioned parties.4)Responsibility for and monitoring for, the corrective actions for F0431:Pharmacy will utilize a monthly schedule of physically auditing the medication and treatment carts and the Medication Room proper; to include, but not limited to, the insulin containers. Pharmacy will provide the Director of Nursing and the facility Administrator with a full copy of their findings during the audit.The Director of Nursing (or her designee) will be responsible for monitoring the carts and the Medication Room, as per the set schedule above	

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			(#3)Non compliant employees will then be identified and counseled in writing, by the Director of Nursing.Any reoccurrences will be followed by placing those employees found responsible into the corrective counseling process	

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F0460 SS=E	Based on observations, the facility failed to ensure all privacy curtains functioned properly affecting 10 out of 36 residents who reside in the facility. The lack of proper functioning privacy curtains affected residents who reside in rooms 1, 3, 5, and 6. Findings included: During the 2/24/11, 10:00 a.m., environmental tour, the privacy curtains for room 1 for both bed spaces would not pull shut with an exposed area of at least 2 feet. There are 2 residents who reside in room 1. The privacy curtain for room 3 bed space 2 would not pull shut with an exposed area of at least 2 feet. There are 2 residents who reside in room 3. In room 5, bed space 1 had no privacy curtain. In room 5, bed space 2, the privacy curtain would not pull shut, with an exposed area of at least 2 feet. There are 2 residents who reside in room 5. In room 6 the privacy curtains would not pull shut with an exposed area from 10 inches to 2 feet. There are 4 residents who reside in room 6.	F0460	F04601) All residents have the potential to be affected by this deficient practice:Although no residents were found to be affected by the small openings in their privacy curtains, the facility recognizes that prudent dignity and privacy practices must be adhered to and that the potential for all residents to be affected by this deficiency must be avoided.Privacy curtain audit has been completed as of this date (3/15/2011).An evaluation of each resident's room and of all common areas has been completed.Rooms 1, 3,5 and 6: The privacy curtain tracks are currently being adjusted by the Maintenance Director. 2) How the facility will ID other resident having the potential to be affected by the same deficient practice and what corrective action will be taken:The Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of	03/26/2011

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	3.1-19(l)(6) 3.1-19(l)(7)		Nursing and the Administrator. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection rounds will be documented in written form. 3) The systemic changes the facility has made, to prevent reoccurrence of this tag:The Administrator and the Maintenance Director made inspection rounds of the resident rooms and common areas on 3/28/2011.The Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing and the Administrator. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection rounds will	

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			be documented in written form.4) Responsibility for and monitoring for, the corrective actions for F0253:The Maintenance Director will be responsible to document all inspection rounds, to include all resident furniture and lighting, in writting and forward these to the Director of Nursing and the Administrator of the facility.The Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing and the Admininstrator. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection rounds will be documented in written form.	

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F0463 SS=D	Based on observation and interview, the facility failed to ensure that all call lights were working. The non functioning call light affected the resident who resides in room 15 bed space 2. The non-functioning call light affected 1 out of 36 residents who reside in the facility. Findings included: During the 2/24/11, 10:00 a.m., environmental tour, the call light in room 15-2 would not turn the light or bell alarm on. During an interview on 2/24/2011 at 12.46 p.m., with the maintenance man, he indicated that the call bell in room 15 bed 2 was working now. 3.1-19(u)(1)	F0463	F04631) What actions will be accomplished for those residents found to have been affected by this dificient practice:As attested in the ISDH survey report 2011, this nonfunctioning call light, once identified, was attended to immediately and in working condition prior to the exit of our surveyors that day.Call lights are checked on a weekly basis for function and more so on a daily basis by the nursing staff who are performing direct patient care. (Although, the nursing checks are not in written form, unless a light is discovered to be malfunctioning and then it is written into the maintenance log book; for the Maintenance Directors daily review.)2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All resident have the potential to be affected by this deficiency.Call lights are checked on a weekly basis for function and more so on a daily basis by the nursing staff who are performing direct patient care.(Although, the nursing checks are not in written form, unless a light is dicovered to be malfunctioning and then it is written into the maintenance log book; for the Maintenance Directors daily review.)The Administrator and the Maintenance Director made inspection/environmental rounds	03/26/2011

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			of the resident rooms and common areas on 2/28/2011. The Maintenance Director will make his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator. To begin March 21st, 2011.These rounds will include call light systems.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing, the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection rounds will be documented in written form.3) The systemic changes the facility has made, to prevent reoccurrence of this tag:The Administrator and the Maintenance Director made inspection/environmental rounds of the resident rooms and common areas on 2/28/2011. The Maintenance Director will make	

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			his inspection rounds in each resident room and all common areas, on a weekly basis for the next three (3) months with a written report given to the Director of Nursing and the Administrator. After three (3) months, the inspection rounds will decrease to bi-weekly for two (2) months; with a written report given to the Director of Nursing and the Administrator.These rounds will include call light systems.After the latter two (2) month period the inspection rounds will decrease to a monthly basis, with written reports given to the Director of Nursing, the Administrator and the Housekeeping Supervisor. There will be 'No Stop Date' placed on the monthly inspection rounds.The Administrator (or her designee) will also make these monthly inspection rounds, accompanied by the Director of Nursing.All inspection/environmental rounds will be documented in written form.4) Responsibility for and monitoring for, the corrective actions for F0463Call lights are checked on a weekly basis for function and more so on a daily basis by the nursing staff who are performing direct patient care. (Although, the nursing checks are not in written form, unless a light is discovered to be malfunctioning and then it is written into the maintenance log book; for the Maintenance Directors daily	

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			review.)The Maintenance Director will be responsible for physically accomplishing and documenting that the inspection/environmental rounds take place as per this aforementioned written schedule	

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F0469 SS=F	Based on observation, record review and interview, the facility failed to ensure they maintained an effective pest control program so the facility was free of flying insects. This had the potential to affect 36 of the 36 residents residing in the facility who ate in the dining room. Findings included: An undated facility policy, received from the Administrator on 2/24/11 at 3:30 p.m. and deemed current, titled "Pest Control" indicated "[name of facility] will strive to maintain a pest free environment for the health and comfort of all our residents and our staff...." The following observations were made: 2/21/11 at 10:30 a.m.: 3 small black bugs were seen flying inside the kitchen near the entry door. 2/21/11 at 10:45 a.m.: approximately 8 small black bugs were seen flying near a trash can placed over a drain in the kitchen by the door exiting into the dining room. 2/22/11 at 9:30 a.m.: approximately 4 small black bugs were seen flying near the same trash can. 2/24/11 at 11:45 a.m.: 1 small black bug was seen flying at the entrance to Room 3.	F0469	F04691) What actions will be accomplished for those residents found to have been affected by the deficient practice: All residents have the potential to be affected by this deficeincy.However, under further review, no resident was affected negatively in this particular instance. The facility is contracted with ORKIN pest control. This provider performed services on 1/26/11 and 2/23/11 in our kitchen/dietary areas.The facility has replaced a non-working electric bug control device.The facility has also ordered another device that is battery powered and fully contained and safe to be located in the kitchen area.Drains inside the kitchen have also been cleaned . 2) How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:All residents have the potential to be affected by this deficeincy.In addition to the corrective actions as listed in number (1);Orkin has provided instructions regarding having a continuous air flow over the drain located under the dish machine. The trash cans in the kitchen will be cleansed thouroughly, daily, inside and out, after each meal service has been completed.Grouted areas around the drains, dishwasher and sink, are being regrouted to provide a tighter	03/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E667	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	2/24/11 at 3:40 p.m.: 1 small black bug was seen flying in room 6. During a group interview on 2/22/11 at 11:00 a.m., all residents present (Residents #6, #1, #20, #29, #7, #14, and #26) indicated there were "gnats" in the dining room. During an interview with Resident #9 on 2/24/11 at 2:30 p.m., she indicated there were "gnats everywhere in the dining room." During an interview with the Maintenance Director on 2/24/11 at 1:30 p.m., he indicated "The pest control people spray the drain in the kitchen and that seems to help." During an interview with the Administrator on 2/24/11 at 11:30 am she indicated "I've talked to the pest control company and asked them to do something." A review of the last receipt from a local pest control company, dated 2/22/11, did not indicate that the company treated the building or rooms for gnats. 3.1-19(f)(3)		seal.The floor drains have been placed on a cleaning schedule that will occur nightly for the remainder of 2011.3) The systemic changes the facility has made, to prevent reoccurrence of this tag: The facility is contracted with ORKIN pest control. This provider performed services on 1/26/11 and 2/23/11 in our kitchen/dietary areas. This contractor has been informed that more measures are required to prevent "gnats" and they are in agreement and will perform the work that is required.The facility has replaced a non-working electric bug control device that is located in a far corner of the dining area.The facility has also ordered another device that is battery powered and fully contained and safe to be located in the kitchen area.Drains inside the kitchen have also been cleaned . Orkin has provided instructions regarding having a continuous air flow over the drain located under the dish machine. The trash cans in the kitchen will be cleansed thouroughly, daily, inside and out, after each meal service has been completed.Grouted areas around the drains, dishwasher and sink, are being regrouted to provide a tighter seal.The floor drains have been placed on a cleaning schedule that will occur nightly for the remainder of 2011.The areas around the	

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			machines will be kept clean and dry on a meal to meal basis to ensure that moisture does not attract these insects.The facility will also continue with all other measures that are in use to prevent reoccurrence.4) Responsibility for and monitoring for, the corrective actions for F0469:The Maintenance Director will assume responsibility to clean drains nightly. Along with regrouting areas around the drains in the kitchen.He will also be responsible for the cleaning of the trash cans daily, inside and out, after each meal service has been completed.The Maintenance Director will also maintain checking insect control products that are utilized by this facility, to ensure workin order, on his scheduled rounds of the interior of the building. (see F253)The Dietary Supervisor will be accountable for ensuring areas around the machines are kept clean and dry.	